Can NICE guidance be given more clout?

Until now it has been difficult to know if trusts are implementing NICE's guidance. New self assessment health checks could make it clearer and increase compliance, writes **Susan Mayor**

One in six trusts of the English health service is not adhering to guidance on the use of treatments from the National Institute for Health and Clinical Excellence (NICE), or does not know whether it is or not, according to the preliminary results from the new annual health check scheme, which are designed to publicly show whether trusts are meeting standards (*BMJ* 2006;333:114, 15 Jul).

The finding echoes reports from doctors' and patients' organisations that the approval of a treatment by NICE does not necessarily mean that trusts will provide it, particularly for some of the newer, more costly drugs. The Audit Commission warned, in a report last year, *Managing the Financial Implications of NICE Guidance*, "Currently, the implementation of NICE guidance by NHS bodies is less comprehensive and timely than desired."

The commission considered that cost was a key factor and recommended that financial aspects of implementing NICE guidance should be integrated into mainstream financial management arrangements.

Cancer drugs have proved particularly problematic. A report published by the national cancer director in 2003 reviewed 16 cancer drugs appraised by NICE plus four standard cancer drugs as comparators. Although overall use of cancer drugs generally increased after positive appraisals from NICE, use varied considerably throughout England. The reasons for variations were complex but seemed to be because of constraints in service capacity and differences in clinical practice. A follow-up report is due soon, based on updated information on the use of the cancer drugs between January and June 2005.

Other relatively costly drugs are also a problem. A report from the MS Trust and the Royal College of Physicians published this week says that the NHS has

barely begun to implement recommendations made more than two years ago on drugs to improve care of people with multiple sclerosis.

The audit looked at whether guidelines published by NICE in November 2003 were being implemented. It concluded, "Current service provision is of low quality and inadequate quantity. Most of the seven recommendations made in the NICE guidelines are not complied with at present, there are few plans to change this, and the standard of data available within organisations would not allow them to monitor compliance or undertake change."

Similarly, one in three rheumatologists (31%) taking part in a survey for the British Society for Rheumatology and the Arthritis and Musculoskeletal Alliance conducted in 2005 said that they were unable to prescribe anti-tumour necrosis factor treatment for every patient that they thought met the NICE guidelines for their use. NICE had approved use of these drugs three years before for patients with severe rheumatoid arthritis in whom existing treatments had failed and who met additional criteria.

A lack of resources was reported to be the main barrier for most cases where rheumatologists could not prescribe anti-tumour necrosis factor treatment to all the patients with rheumatoid arthritis that they considered appropriate. A spokesperson for Arthritis Care said that they had seen nothing over the past year to indicate that the situation had improved.

How is implementation of NICE guidance monitored? NICE was set up in 1999 to advise the NHS in England and Wales on the use of treatments through technology appraisals—assessments on the clinical and cost effectiveness of specific drugs or other treatments—and guidelines on best practice and

clinical management for specific conditions. One of the aims of its introduction was to stop "postcode prescribing," in which patients in some areas of the country could get certain treatments while people in other areas could not.

Trusts are legally obliged to act on NICE's recommendations. The Department of Health issued directions in December 2001 placing statutory obligations on the NHS to provide appropriate funding for recommended treatments within three months of NICE issuing guidance. The problem has been that none of the systems used to monitor implementation of NICE guidance have worked so far.

Michael Rawlins, chairman of NICE, whose recommendations are being flouted, particularly in the area of cancer, multiple sclerosis, and rheumatology

Initially, implementation of NICE guidance was monitored by the Commission for Health Improvement, which had overarching responsibility for the entire quality system in the NHS. In 2002, the Commission for Healthcare Audit and Inspection subsumed the old commission, with additional responsibility for auditing and inspecting healthcare providers. The emphasis on inspection implied a harder edged and wider regulatory function including assessing whether NICE guidelines were followed.

Implementation of NICE's guidance in England moved to

the Healthcare Commission in England when it was set up in 2004. Healthcare Inspectorate Wales, based within the National Assembly for Wales, takes this role in Wales. In the commission's "annual health check" of the NHS, trusts provide self assessments on 44 core standards, including whether they "conform to... NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care." The first results showed that 15.4% of trusts said they either were not meeting this standard or had insufficient evidence that they were.

Anna Walker, the chief executive of the Healthcare Commission, said that it will be working with trusts that fail to meet standards, including conforming to NICE's guidance. She said, "A trust that declares non-compliance with some of the standards is one we want to work with. The standards are not optional." She added, "Where a trust has declared significant non-compliance we will be following that up with them and their strategic health authority." Results from the annual health check will also be made publicly available.

The first set of annual health check assessments will be formally published in October. Last week's publication of the performance of 570 trusts was preliminary. Health inspectors are going to check over the next few weeks whether the figures reflect differences in performance or boards' willingness to be truthfully self critical.

Alan Maynard, a health economist at York University, said that the new checks might encourage trusts to review what is happening in their area because "they should be aware of what they are doing and often they are not." However, limited resources may hamper the process and the honesty of trusts may be difficult to assess.

"This is uncharted territory," Professor Maynard told the *BMJ*. "There is no sampling of how honest trusts are being so it will be interesting to see what comes out of this."

The aim is that trusts will then compare themselves against the core standards in a system based on self assessment. Only time will tell if this extends to implementation of NICE's guidance. ■

Susan Mayor *London*